TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-15-1192-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOB and claim with the TDI Rule 134.600 attached. The claim was denied based on services denied at the time pre-authorized requested. According to our records, CPT CODE 90791 INITIAL PSYCH EVALUATION doesn't require pre-authorization.

TDI Per Rule 134.600 (p) only all psych testing and psychotherapy, repeat interviews and biofeedback are required pre-authorization.

The initial psych evaluation doesn't require pre-authorization so none was requested/obtained due to doesn't fall in the category above for pre-authorization."

Amount in Dispute: $1,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 05, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 03, 2014	CPT Code 90791	$1,250.00	$204.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 Texas Administrative Code §137.100 sets out the procedures for treatment guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 – Services denied at the time authorization/pre-certification was requested
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments

Issues

1. Did the services in dispute require preauthorization?
2. Is CPT Code 90791 a timed unit code?
3. What is the Maximum Allowable Reimbursement (MAR) for CPT Code 90791?
4. Is the requestor entitled to reimbursement?

Findings

1. This service was denied by the respondent with reason code "39 – Services denied at the time authorization/precertification was requested and BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments."

   28 Texas Administrative Code §134.600 (p)(12) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier …"

   Pursuant to 28 Texas Administrative Code §137.100 (a) "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)." Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   Pursuant to 28 Texas Administrative Code §137.100 (f), "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

   Review of the January 2014 ODG low back chapter under the psychological screening section finds that psychiatric diagnostic evaluation is "Recommended". The division concludes that the services were provided in accordance with the 28 Texas Administrative Code §137.100. As a result, preauthorization is not required for CPT Code 90791. The requestor is therefore entitled to reimbursement pursuant to 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203 states "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestors CMS-1500 billing form reviewed which indicates CPT Code 90791 x 5 units. The description of CPT Code 90791 is as follows: A psychiatric diagnostic evaluation is performed, which includes the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed appropriate treatment recommendations. This is not a time unit code; as a result, the requestor is entitled to one unit of CPT Code 90791. Reimbursement is calculated pursuant to 28 Texas Administrative Code §134.203(c).

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year ..." The requestor seeks $1,250.00 for CPT Code 90791. The MAR reimbursement is $204.43, therefore, this amount is recommended.
4. Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT Code 90801 rendered on January 03, 2014 in the amount of $204.43.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $204.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $204.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		8/28/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.